EXHIBIT 8

HAVENWYCK HOSPITAL
1525 University Drive
Auburn Hills, MI 48326

Patient Name:	ELZEIN, AHMED
Physician:	DO SYNG YOON, MD
MRN:	097619
Admit Date:	11/12/2020
Discharge Date:	11/17/2020
Unit:	

RESULTS OF ASSESSMENTS AND SIGNIFICANT FINDINGS:

a. **History, Physical and Neurological Examination:** The history and physical assessment was completed by Dr. Kale. The results of the assessment were as follows: Foot calluses and flat feet. EKG revealed left ventricular hypertrophy. Discussed sleep hygiene and follow up with psychiatrist. Patient would benefit from a 2D echo.

b. **Psychological Testing:** Not indicated.

c. **Laboratory Testing:** Vitamin D 25-hydroxy 6.9, decreased.

d. **Activities:** Treatment goals/activities: Patient was admitted to the inpatient psychiatric unit, where he was to be involved in individual and group psychotherapy along with milieu activities. Specific goals were to reduce psychosis, improve insight, and improve coping strategies. He was placed on precautions, provided therapeutic modalities, medication management, social work consultation for social history, milieu support with aftercare followup. He is to return home and follow up with outpatient services upon stabilization.

CLINICAL COURSE: The patient is a 27-year-old single Middle Eastern male, who was admitted to the inpatient psychiatric unit as he was very suspicious, paranoid, and delusional. He believed people were putting harmful objects in his pocket. He stated he was not doing well and was tired and lacked sleep.

HISTORY OF PRESENT ILLNESS: He has had no previous psychiatric treatment. He stated he was overworking. He was tired with lack of sleep and his friends became concerned about him, but he did not go into details. He was suspicious, paranoid, and delusional. He believes that people were putting harmful objects in his pocket such as poisons. His training director became very concerned.

PAST PSYCHIATRIC HISTORY: None identified.

SUBSTANCE ABUSE/DEPENDENCE: None.

FAMILY/SOCIAL HISTORY: He had been living alone, working as an internal medicine resident. His parents were married and living together and he grew up with them. He denied abuse while growing up. He denied any legal issues. He denied family history of mental illness. He is employed as an internal medicine resident.

MENTAL STATUS EXAMINATION: He presented as casually dressed and guarded as well as evasive. His psychomotor activity was within normal limits and affect blunted. Mood was anxious. Speech was normal.

His thought process was logical. He was paranoid and delusional. He is not expressing suicidal or homicidal thoughts. He is fully oriented. Concentration was intact and he was able to stay focused in conversation. Recent and remote memory were intact as was abstract reasoning ability. Intellectual capacity was in the average range. Insight and judgment were poor.

HOSPITAL COURSE: Following admission, he was maintained on precautions. He appeared guarded. He was becoming irritable at times and denied hearing voices. Speech was normal and mood was stable. Insight and judgment were poor. Mood was depressed and anxious. His affect was blunted. His thought process was circumstantial. He denied hallucinations. He was not sleeping well. He was attending groups and activities. He appeared to be evasive. He was less paranoid, attributed the paranoia to lack of sleep and being stressed prior to admission. Risperdal was adjusted to 2 mg b.i.d. He stated his father was going to stay with him for 4 months. He felt more positive and relaxed. He recognized the benefits from the medication. Mood was stable and affect was appropriate. He is not verbal of paranoid delusions. Insight and judgment were fair. He reached maximum benefit from this hospitalization. He was prepared to follow up with aftercare services.

RECOMMENDATIONS: Post-discharge followup: He was to follow up through Oakland Psychological Clinic on November 21, 2020, at 12 p.m. with Ken Lafleur. He was referred to Grand Blanc Parks and Recreation Services. Diet: Regular. Activity restrictions: Not applicable. He declined smoking cessation medication. He was to follow up with his primary care physician.

DISCHARGE MEDICATIONS: Risperdal 2 mg b.i.d.

PROGNOSIS: Fair.

FINAL DIAGNOSES:
Psychiatric: Psychotic disorder, not otherwise specified (NOS).
Medical: None.
Psychosocial and Contextual Factors: To be further assessed.

PSYCHIATRIC FUNCTIONING AT DISCHARGE: Stable.

MEDICAL FUNCTIONING AT DISCHARGE: N/A.

Dictated by:

Electronically Signed on 12/09/2020 11:56:22 AM (GMT 5:0)
Tina Kaplan,

HAVENWYCK HOSPITAL

Patient Name: ELZEIN, AHMED **MRN:** 097619

Authenticated by:

Electronically Signed on 12/10/2020 01:02:40 PM (GMT 5:0)
Do Syng Yoon, MD

SK/lc/cb

DD: 12/06/2020 12:14:05 PM
DT: 12/08/2020 11:34:10 AM
Job #: T1348734

DISCHARGE SUMMARY AND AFTERCARE PLAN